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Prevention and intervention for anxiety disorders in children and adolescents: A whole school approach.

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Abstract

This paper explores a whole school approach to the prevention and intervention for anxiety disorders in children and adolescents. Anxiety disorders are the most prevalent psychopathology in childhood and adolescence. In addition to having serious consequences for academic, social and family life, anxiety has also been shown to be a precursor to depression, substance abuse and eating disorders. School counsellors are well placed to identify students with anxiety disorders, instigate prevention programs and treat or refer anxious students. Prevention and early intervention for anxiety disorders needs to be co-ordinated and integrated into the regular curriculum as well as into the life of the classroom and the school. Barriers to schools working well in this area are identified and discussed.

Anxiety in childhood and adolescence is common. However, most anxiety is functional and beneficial, providing motivation and inhibiting excessive risk-taking. However, for a significant minority of young people, their anxiety causes such interference in their daily lives or is so developmentally inappropriate, that it becomes a disorder. It is estimated that anxiety disorders can affect up to 18% of 6-17 year-olds (Costello & Angold, 1995; Kashani & Orvaschel, 1990). In fact, excessive anxiety is the most prevalent type of disorder experienced by children and young people (Albano, Chorpita & Barlow, 1996; Verhulst, van der Ende, Ferdinand, & Kasius, 1997). This means in an average Pre to Year 12 school of say 1000 students, there could be up to 100 children and young people with an anxiety disorder. This is of course, not including those who have sub-clinical symptoms or those at risk of developing a disorder.

However, depression prevention and treatment seems to be “getting all the press” in schools and government funding. While this is laudable and necessary, having an anxiety disorder may actually increase the risk of developing a depressive disorder (Breier, Charney, & Heninger, 1984; Kovacs, Akiskal, Gatsonis, & Parrone, 1994). It has been proposed (Dobson, 1985) that anxiety and depression lie on a developmental continuum and that anxiety predates depression. In fact, recent evidence suggests that childhood anxiety may play a causal role in the development of depression among young people (Cole, Peeke, Martin, Truglio, & Senczynski, 1998). Also, there is some evidence that when occurring together, anxiety disorders may persist longer than depressive disorders (Bernstein, Hektner, Borchardt, & McMillan, 2001) as well as preceding them.

Co-morbidity

Anxiety has also been associated with other conditions. In adolescents who were diagnosed with an anxiety disorder, over 70% had another mental disorder (Lewinsohn, Zinbarg, Seeley, Lewinsohn, & Sack, 1997). As well as the many studies that have shown that anxiety is co-morbid with depression (Brady & Kendall, 1992; Last, Hansen, & Franco, 1997; Manassis & Menna, 1999), anxiety is also co-morbid with the ‘externalising’ disorders such as attention deficit disorder, conduct disorder and oppositional defiant disorder (Anderson, Williams, McGee, & Silva, 1987; Last, Strauss, & Francis, 1987; Russo & Beidel, 1994).

Eating Disorders

Anxiety disorders are also co-morbid with eating disorders (Schwalberg, Barlow, Alger, & Howard, 1992; Wonderlich & Mitchell, 1997). In particular social anxiety (Blanco, Nissenson, & Liebowitz, 2001) and perfectionism (Bulik et al., 2003) have been found to be strongly associated with eating disorders. In addition, anxiety disorders have been shown to precede the eating disorder in most cases (Godart, Flament, Lecrubier, & Jeammet, 2000). Furthermore, anxiety disorders that were based on self-reports of early adolescents predicted several types of eating and weight problems during middle adolescence, but anxiety data from the students’ mothers did not predict subsequent eating disorder diagnosis (Johnson, Cohen, Kotler, Kasen, & Brook, 2002).

Substance Abuse

There is growing evidence to suggest that as well as disruptive behaviour disorders and aggression being precursors to substance abuse in adolescence, internalising disorders such as anxiety and depression are also associated with this disorder (Rao et al., 1999). There is preliminary evidence to suggest that anxiety disorders may predispose adolescents to the development of substance use disorders (Burke, Burke, & Rae, 1994; Deas-Nesmith, Brady, & Campbell, 1998; Rodhe, Lewinsohn, & Selby, 1996). In addition, adolescent mood disorders have been shown to increase the risk of adult substance abuse disorders (Deykin, Buka, & Zeena, 1992).

Consequences

As well as being co-morbid with other conditions, excessive anxiety is debilitating enough alone. Children with anxiety disorders have been shown to have lower academic achievement (Ialongo, Edlesohn, Werthamer-Larsson, Crockett, & Kellam, 1994; Ialongo et al., 1995), peer relationship problems (Strauss, Frame, & Forehand, 1987) and impairments in general social competence (Messer & Beidel, 1994). Excessive school absenteeism and impaired peer relationships associated with anxiety lead to poor vocational adjustment (Hibbert, Fogelman, & Manor, 1990) and self-concept problems (Asher & Coie, 1990) as well as psychiatric disorders later in life (Kovacs & Devlin, 1998).

Barriers to Dealing with Anxiety

Why then aren't schools treating anxiety more seriously? Perhaps it is because depression is a known risk factor for suicide (Fergusson & Woodward, 2002; Hagedorn & Omar, 2002). However, it has also been shown that there is an increasing risk of suicide as a consequence of anxiety (Mattison, 1988). Or is it that we all experience anxiety? Is it such a ubiquitous and normal emotion that excessive anxiety seems 'normal' to us? Or are we scared by anxiety? Does the anxiety of others evoke our own anxiety to such an extent that we feel powerless to help? Or do schools hold on to the old fashioned idea that extreme anxiety is transient in most children and adolescents. A study conducted by Pine, Cohen, Gurley, Brook and Ma (1998) is one of many which have shown that this is not true. Adolescents who had an anxiety disorder for longer than 9 years were two to three times more likely to have an anxiety disorder in early adulthood. There was a surprising specificity of anxiety disorder. That is, social phobia at time one predicted social phobia at follow-up, while simple phobia predicted simple phobia. Thus, an anxiety disorder in adolescence is a strong risk factor for an anxiety disorder as an adult (Kovacs & Devlin, 1998). Children with an anxiety disorder are also at serious risk for ongoing morbidity (Beidel, Flink, & Turner, 1996; Mattison, 1992; Pollack, Otto, Sabatino, & Majcher, 1996). In fact untreated anxiety disorders can persist for up to 8 years (Kovacs & Devlin, 1998).

Perhaps schools are not treating anxiety more seriously because excessive anxiety is not easily recognised except when it manifests as school refusal, which in younger children can be separation anxiety or in adolescence social phobia? Children and adolescents showing school refusal behaviour commonly present with anxiety and/or depressive disorders (Bernstein, 1991). There is also the difficulty of making a differential diagnosis with ASD and ADHD in very complex cases (Manassis & Monga, 2001). Perhaps school counsellors feel they lack the skills to treat anxious students or that there are limited

places to refer anxious children. Alternatively, it could be a resourcing issue because externalising problems of children and young people, which disrupt others learning in school, are seen to be more important?

We know there is under-identification of internalising disorders because by their very nature they are 'hidden' disorders. Children and young people are embarrassed about being anxious. They 'fake good' (Kendall, 1994) but the signs of anxiety are there. There is also under servicing of even those anxious students who are identified. The majority of children with anxiety disorders do not receive needed treatment (Sawyer et al., 2002; Zubrick et al., 1997). Yet we know that the prognosis for these young people is significantly poorer than those who are treated (Dadds, Barrett, & Cobham, 1997).

Whatever the reasons are for anxiety not "getting the press" and the funding, it is important for schools, nonetheless, to participate in the prevention and treatment of excessive anxiety in children and young people.

Schools, and especially school counsellors, are well placed to promote wellness and resilience, to instigate prevention programs and identify and treat or refer anxious students. School guidance counsellors and school psychologists are usually doubly qualified. They are teachers and also counsellors or psychologists. This means they are perfectly placed to understand the developmental considerations of children and adolescents as well as the unique culture that is school. Sawyer et al. (2002) found that in Australia, after family doctors, school-based counsellors provided the services that are the most frequently used by children with mental health problems. For adolescents, school based counselling was the service most frequently used. Children and young people are greatly influenced by their family and peer environment, of which the school is a significant part.

Just as we recognise that bullying needs a whole school systemic approach (Smith & Sharp, 1994) with prevention education as well as individual approaches for the bully and the victim, equally anxiety in schools needs a comprehensive program. This means that schools become aware of and provide for anxiety reduction both in the curriculum, in the form of direct instruction, as well as in the hidden curriculum. There needs to be continuity, from promotion, to universal prevention programs and processes for referral, to various levels of treatment within and linked to, the school (Elias & Weissberg, 2000). Individual lessons or short programs by themselves are not sufficient if the learning from such programs is to be sustained. Emotional and social skills cannot be taught in one lesson each week (often only for 10 weeks) and not practised and reinforced continuously in all aspects of living to facilitate generalisation and sustainability. Prevention and early intervention for excessive anxiety needs to be co-ordinated and integrated not only into the regular curriculum but also into the life of the classroom and the playground. Not only the school as a whole but also students' families and the broader community need to be included. Mental health is everybody's business and responsibility (National Health Plan, 2003). This multi-level promotion, prevention and intervention strategy is necessary if real change is to occur (Winnett, 1998).

Prevention Strategies

In recent years there has been a paradigm shift in research on childhood anxiety disorders towards prevention, but this has not yet been translated into work place practice, especially in schools. This is not however, confined to schools. Many mental health

workers feel they do not have the skills to conduct prevention programs (Spence, 1994) or they hold irrational beliefs that they do not have time to engage in preventative efforts because of the perception that prevention does not work (Hightower & Braden, 1991). In addition, prevention work is costly, but of course not as costly as not doing it.

Awareness Raising

However, prevention should be the first component of a comprehensive program in schools dealing with anxiety. School counsellors can take the lead in raising the awareness of anxiety in the school, for example, by presenting at a staff meeting, explaining to staff about the 'hidden' good kids. That is, anxious children usually have a great desire to please and are therefore usually compliant and non-disruptive (Kendall, 1994). Because of the nature of schooling, scarce mental health resources are usually used first for externalising problems or disruptive children. However, when the consequences of untreated anxiety are explained then teachers may see the need for resources to be more equitably distributed. School counsellors can inform teachers about the signs and symptoms of excessive anxiety in the classroom. For example, children with excessive anxiety may have difficulty getting along with others, suffer from low self-esteem and try desperately not to let anyone know how frightened and worried they feel. Other signs to be aware of are: avoidance behaviours, procrastination, perfectionism, overly conformist, hypersensitive to criticism, poor social skills, unsure of self, shy and retiring, becomes upset over changes in routine, requires constant reassurance, worries a lot, is scared of leaving parents or facing new situations, cries easily or frequently complains of headaches and stomach aches.

Classroom Climate

Talk with interested teachers about creating classroom climates that are conducive to confident learning. Explain strategies such as the teacher deliberately making a mistake in the classroom. Anxious children fear making any mistake in front of others. They feel excessive anxiety from exaggerating the threat of failure and that others will think badly of them. Usually the reaction of the class is to point the mistake out vociferously and then to burst into laughter. This can be used to explain about feeling hurt by others laughing at the mistake. The message then becomes that this is a 'have-a-go' classroom and mistakes are OK. This encourages risk taking in learning in all areas of academia as well as in emotional growth and can prevent excessive anxiety from fear of failure and fear of negative evaluation in the classroom.

Another classroom climate strategy is rewarding for effort. Teachers traditionally reward achievement and every now and again reward effort. If students are rewarded for effort constantly, then presumably, by the principle of behaviour that what is rewarded tends to be repeated, all children would try more. Anxious children often won't try in case they fail. They can't start writing because they don't want to spoil the white page. They procrastinate and won't start the project for fear of failing and not producing a perfect result. Rewarding for effort is vital for these children.

Classroom Instruction

In addition to classroom climate, schools can contribute to the prevention and early intervention of excessive anxiety in students by directly teaching about handling fears and worries. This can be done in many different ways. Firstly, there are programs suitable for teaching in small groups such as *Coping Koala* (Barrett, Dadds, & Holland, 1994). Although this program was originally written as a treatment program for anxious children it has been also found to be useful as a prevention program (Dadds, et al., 1999). The *Coping Koala* program has also been modified and renamed *Friends for Children* program. This program has also been found to be effective as a prevention program with primary school children (Barrett & Turner, 2001; Lowry-Webster, Barrett, & Dadds, 2001). As risk and protective factors are common to many disorders, especially internalising disorders, many resiliency programs can also be used for anxiety prevention. Programs such as the *Resourceful Adolescent Program* (RAP: Shochet & Osgarby, 1999) and *Adolescents Coping with Emotion* (ACE) have been shown to reduce anxiety symptoms when they were actually targeting depression symptoms (Hannan, Rapee, & Hudson, 2000). Many studies have found that the treatment effects of prevention programs were larger at long term follow-up than they were immediately after the program (Kendall, Brady, & Verduin, 2001; Toren et al., 2000). It has been hypothesised that prevention programs could therefore function to inoculate children against internalising disorders by teaching them adaptive cognitive and social skills (Gillham, Reivich, Jaycox, & Seligman, 1995).

The school can also look at prevention of excessive anxiety through other programs such as primary to high school transition programs as well as the provision of home-rooms in secondary schools and buddy systems.

Bibliotherapy

A strategy which can be embedded into the curriculum is the use of books. Although bibliotherapy has a different meaning when used in psychology as opposed to education, the use of self-help books or manualised workbooks has been shown to assist in reduction of flying phobia (Beckham, Vrana, May, Gustafon, & Smith, 1990), social phobia (Jerremalm, Jansson, & Ost, 1986) and test anxiety (Register, Beckham, May, & Gustafon, 1991). However, for school counsellors, the kind of books to use with students is more likely to be fiction books. Bibliotherapy is well designed to fit into the school curriculum without the “add on” style of many manualised programs. It allows teachers the freedom to incorporate the topic of the story into any of their lessons. Involving teachers in collaboratively devising programs for them to implement in their classrooms would seem to be more productive than ‘training’ teachers in one day to deliver prepackaged programs. Allowing teachers to participate in the modification of programs to suit their teaching style and students has been shown to have a beneficial effect on students’ learning (Wade, Davidson, & O’Dea, 2002). In addition, the manualised programs are often more traditionally based on didactic presentations with students filling in workbooks. However, teaching based on co-operative, interactive and student-centered learning has been shown to enhance student learning (Hill & Hill, 1990).

There are many non-fiction books dealing with feelings such as Crary’s (1994) *I’m Scared*, as well as fiction books: From books for preschoolers such as Waddell’s (1999) *Can’t you sleep, little bear?* and Varney’s (1995) *Jelly legs*, to books suitable for primary school

students such as Browne's (1995) *Willy the wimp* and Campbell's (2003) *Cilla the worried gorilla* to secondary school students Duff's (1999) *Duffy's once were worriers* and Ruth Park's (1989) *Things in corners*.

The Teachable Moment

One of the best strategies is of course, 'the teachable moment.' It happens with frogs brought to class; from the life cycle of the frog, to environmental issues, from frogs in poetry and music to scientific observation. The same can be accomplished with helping young people deal with emotions. There are literally thousands of opportunities in class and outside to use naturally occurring events to show how to deal with emotions. From the nervousness of speaking in front of the class for "Show and Tell" to sitting for examinations, to dealing with irrational fear of dogs to procrastination and avoidance behaviours.

In fact, schools are already implementing many of these aspects of prevention. The inclusion of teaching about feelings by songs, books, puppets and role plays in health and personal development programs, the beginnings of transition to high school programs and some exciting early intervention work through Mind Matters materials is already happening in schools. Therefore, the inclusion of a whole school approach to anxiety should not be seen as an extra, in an already overcrowded curriculum but as a heightened sense of awareness and sensitivity to the issue with a whole school planned approach.

Assessment of Anxiety Disorders

Identification issues are beyond the scope of this paper, however, readers are directed to other papers such as Campbell and Rapee (1994) and Schniering, Hudson and Rapee (2000) for a fuller discussion. Manassis and Monga (2001) provide information on overcoming some of the difficulties of differential diagnosis of anxiety and ASD, ADHD and OCD for those who are interested. In general, best practice seems to rely on multi-informants (teachers, parents and students) with multi-methods (self-report, other report and observations).

The idea of large scale screening for emotional disorders, especially for anxiety and depression, does not seem to be widespread in schools. Yet screening for physical disorders and academic difficulties seems to be routine. However, self-report measures are available (such as the Spence Children's Anxiety Scale and the Beck Youth Scales) which could assist not only in identification of students but also in baseline data for any preventative programs. An exciting initiative in two Mind Matters Plus demonstration schools is the identification of students at risk of developing an emotional disorder and identification of students who show early signs and symptoms of a disorder. These schools have conducted a combination of teacher referral, school support team identification together with a battery of self-report questionnaires.

Interventions

Once identification processes have been completed then interventions can be put into place. Many strategies for treating anxious youth have, as their fundamental component,

exposure. In fact, Silverman (2001) thinks this could be the only strategy that is essential. However, most other programs for anxious youth prepare the students beforehand with strategies on how to cope with the exposure. Most published programs which are evidenced-based are cognitive behavioural therapy programs. Evidence for other interventions such as play therapy, psychodynamic therapy or family therapy has as yet not been demonstrated for anxiety disorders (Labellarte, Ginsburg, & Walkup, 1999). These programs are usually designed for use in middle childhood (Dadds, Spence, Holland, Barrett, & Laurens, 1997).

Kendall has published a treatment manual (Kendall, Kane, Howard, & Siqueland, 1990) and a children's workbook to accompany it called *Coping Cat* (Kendall, 1990). This consists of a 16-week program which combines educational and exposure strategies. The first eight sessions teach children to recognise and manage their anxiety. To facilitate recall of the steps for coping, children are taught the acronym 'FEAR' for Feelings, Expectations, Actions, Reward. The second set of eight sessions are imaginal and in vivo exposure utilising their FEAR plan. Studies have shown that this program was effective in clinical randomised trials, firstly in 1994 (Kendall, 1994) where the effectiveness of the program was compared with a wait-list control. Sixty-four percent of the children in the treatment group had no anxiety diagnosis at the end of treatment compared with five percent of the wait-list controls. These gains were maintained at one-year follow-up and again between two and five years later (Kendall & Southam-Gerow, 1996). A replication of Kendall's (1994) study showed similar clinically significant results (Kendall et al., 1997).

Kendall's work was adapted for Australian children by Barrett, Dadds and Rapee (1996) and called the *Coping Koala* program. Seventy-two percent of children who completed the program no longer met diagnostic criteria for an anxiety disorder after one year. This research also included a treatment condition that combined the *Coping Koala* program with a family management program. Although more of these children improved compared to those who received the *Coping Koala* program alone, six years later the gains were not maintained and both groups were similar (Barrett, Duffy, Dadds, & Rapee, 2001).

Other Australian researchers have also developed anxiety treatment programs such as Cobham's (1999) *Facing Your Fears* and Campbell's (2003) *Worrybusters* program. Cobham (1999) has developed a seven session cognitive behavioural program for children called *Facing Your Fears* and a six session parent program called *Do as I Do*. Both programs are run concurrently. Campbell's (2003) program called *Worrybusters* is also based on cognitive behaviour therapy but has added imagery and choice into the program. The main image is one of a journey (the exposure in overcoming fears and worries). Children then prepare for the journey by selection of tools, food and clothing as metaphors for a menu of coping skills. The program is designed to individualise coping strategies for each child as suggested by Eisen and Silverman (1998).

A new approach for the delivery of anxiety programs is the use of cross-age coaching for adolescents and children. Many studies have shown the benefits in reading of cross age coaching (Giesecke & Cartledge, 1993) where the older poorer reader gets as much benefit from the coaching as the younger poorer reader. This concept is being used in a study currently underway where anxious Year 9 adolescents are conducting the *Worrybusters* program for anxious Year 4 and 5 students.

Most of the studies have found that group treatment is equally effective as individual treatment (Manassis et al., 2002). Furthermore, recent studies have shown that co-

morbidity with other disorders does not aversively affect treatment results (Kendall, et al., 2001). Evidence for these programs is strong but has as yet not been compared extensively with other modalities. Furthermore, the active treatment components responsible for these programs' effectiveness have not yet been identified (Compton, Burns, Egger, & Robertson, 2002). School counsellors need to modify these programs both for the individual child as well as providing for individual differences in group treatment.

Parental Involvement

As well as treating anxious children, it is important to consider their parents. There is increasing evidence of the familial nature of anxiety disorders (Manassis & Bradley, 1994). Last, Hersen, Kazdin, Orvaschel, and Perrin (1994) showed that parents of children who were referred to a clinic for anxiety disorder, had a relatively high chance of experiencing the same type of disorder. Not only has parental psychopathology been implicated as a correlate of anxiety disorders in children (Manassis & Hood, 1998) even parental modelling can effect development of phobias in children (DeJong, Andrea, & Muris, 1997; King, Clowes-Hollins, & Ollendick, 1997). Families of anxious children have been described as criticizing and granting less autonomy to their children (Whaley, Pinto, & Sigman, 1999). In addition, they are described as disengaged and rigid (Bernstein, Warren, Massie, & Thuras, 1999). Parents of anxious children have been shown to model, prompt and reinforce anxious behaviours in their children (Barrett, Dadds, Rapee, & Ryan, 1996). Rapee (1997) showed that parental overprotection and overcontrol undermines children's confidence and interferes with their problem solving skills. Often there is parental disagreement shown in an increase in family conflict as parents have different ways and views on how to handle the child's anxiety problems (Ginsburg, Silverman, & Kurtines, 1995). It has been shown that perceived parental frustration with the anxious child predicts reduced child improvement in treatment (Crawford & Manassis, 2001). In addition, Cobham, Dadds, & Spence (1998) found that parents with a high level of anxiety themselves were a risk factor for their child's failure with cognitive behaviour treatment.

When working with anxious children it is important to also talk with parents.

Some parents, who are emotionally overattached to their anxious child, find it difficult not to 'overhelp'. Explaining that by overhelping we are telling the child by implication she is incompetent can assist these parents. This kind of parenting prevents children from learning to problem solve for themselves. Gently challenge parents to see if their child feels challenged and capable or discouraged and stupid. Explain the fine line between keeping children in cotton wool and yet protecting them. On the other hand, with overcontrolling parents it is important to explain to them that the more worried one gets about one's children the more often one clamps down on them and this doesn't allow the child to manage their own feelings.

In treatment studies it has been shown that anxious children's use of active coping strategies was increased in a group intervention by parental involvement in the program (Mendlowitz et al. 1999). When parents were involved with therapy Crawford and Manassis (2001) found that there was decreased parental frustration. Similarly Barrett (1998) found that group cognitive behaviour therapy plus a family training component was effective in reducing anxiety symptoms in children even though the effects did not last at six-year follow-up (Barrett et al., 2001).

With very young children there seems to be two risk factors in the development of anxiety disorders. One is the quality of attachment between the mother and child (Manassis, Bradley, Goldberg, Hood, & Swinson, 1994) and temperamental factors (Caspi, Henry, McGee, Moffitt, & Silva, 1995). Thus, working with parents or the parent-child dyad may be more preventative of anxiety than treating preschoolers individually (Bernstein, Borchardt, & Perwien, 1996). LaFreniere and Capuano (1997) identified preschoolers who exhibited anxious-withdrawn behaviour. After a 6 months prevention program working with parents, mothers in the treatment group exhibited less intrusive and overcontrolling behaviour compared to mothers in the control group. The target children increased in social competence and co-operation. However, all anxious-withdrawn children were significantly improved at the end of 6 months.

Conclusion

School counsellors are well positioned to advocate for a whole school approach to anxiety. The challenge for school counsellors is to incorporate anxiety prevention programs into the curriculum as well as the hidden curriculum or culture of the school. In addition, they need to provide early intervention in the school and pathways to care for students outside the school. A whole school program can be developed by using some of the strategies suggested in this paper. It may be appropriate to begin with one strategy and integrate others over time where appropriate according to available resources, the student's needs, teacher awareness and the parents involved.

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